Hospital Coverage Letter

Family Practice, General Practice, Geriatric Medicine, Internal Medicine, Pediatrics, and Physician Medicine confined to Outpatient Practice

Date: _____________

Physician Name and Credentials: ____

Please accept this correspondence as confirmation that since I do not have privileges at a PAR hospital, except for medical emergencies, my practice will be confined to outpatient.

If non-emergency hospitalization is necessary, I will refer care to a network provider that has active admitting privileges at a PAR network facility.

______________________________________ ___________________________

Physician Signature Specialty

Physician Coverage Letter

Date: ____________

I understand that the physician listed above is undergoing credentialing with Genesis Physicians Group and does not have admitting privileges at a PAR network facility. I will cover any admissions that he/she may have.

______________________________________ ___________________________

Physician/Group Name Specialty

List of Active Affiliated Hospitals:

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